

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and replace. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 35421

1. DECEASED NAME (TYPE OR PRINT) THOMAS HARDCASTLE BAYNARD			2a. DATE OF DEATH MONTH DAY YEAR Nov. 24, 1987		2b. HOUR 8:15A.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Nov. 28, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD.		
12. CITY OR TOWN OF DEATH DENTON	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 205 NORTH 6th Street		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kennel Manager		15. KIND OF BUSINESS OR INDUSTRY Veterinarian	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY CAROLINE 13c. CITY OR TOWN DENTON		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS 205 NORTH SIXTH STREET		
19. FATHER'S NAME FIRST MIDDLE LAST Ferdinand Baynard		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Parris				
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		22. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 217053752		23. INFORMANT ADDRESS Connie Williamson, Denton, MD 21629		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>year</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)						
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE		
35. I certify that (I) (this hospital) attended the deceased from <u>4/11/66</u> 19 <u>82</u> , to <u>11/5</u> 19 <u>82</u> , that (I) <u>last</u> saw the deceased alive on <u>11/9/82</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not) view the body after death.						
36. SIGNATURE <u>Phil. P. Felipe, MD</u>		37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 11/24/87		
39. PHYSICIAN'S NAME (TYPE OR PRINT) Phil. P. Felipe, MD		40. ADDRESS 420 S 5th Ave Denton, Md				
41. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		42. DATE 11/27/87		43. NAME OF CEMETERY OR CREMATORY DENTON CH.		44. LOCATION CITY OR TOWN COUNTY STATE DENTON CAROLINE MD
45. FUNERAL DIRECTOR NAME Randolph P. Moore		46. ADDRESS Denton, Maryland		47. DATE REC'D. BY REGISTRAR DEC 01 1987		48. REGISTRAR'S SIGNATURE <u>Wesley Gordon-Randall</u>

BP

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodide in aqueous solution. The methodology involves measuring the rate of reaction at different temperatures and using the Arrhenius equation to determine the activation energy.

2. The second part of the report is a detailed description of the experimental procedure. It includes the list of materials, the list of equipment, the list of reagents, and the list of procedures. The materials are hydrogen peroxide, potassium iodide, and sulfuric acid. The equipment includes a thermometer, a stopwatch, and a graduated cylinder. The reagents are hydrogen peroxide, potassium iodide, and sulfuric acid. The procedures involve measuring the rate of reaction at different temperatures and using the Arrhenius equation to determine the activation energy.

3. The third part of the report is a discussion of the results. It includes a table of the data, a graph of the data, and a conclusion. The data shows that the rate of reaction increases with temperature. The graph shows a linear relationship between the natural logarithm of the rate constant and the inverse of the absolute temperature. The conclusion is that the rate of reaction increases with temperature and that the activation energy of the reaction is approximately 50 kJ/mol.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified and a medical certificate must be completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 35422

1. DECEASED NAME (TYPE OR PRINT) <b>NELLIE G. BONNER</b>		2a. DATE OF DEATH MONTH <b>12</b> DAY <b>20</b> YEAR <b>87</b>		2b. HOUR <b>11:20P</b>	
3. SEX <b>F</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>04</b> YEAR <b>03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b> MD.	
10. CITY OR TOWN OF DEATH <b>Federalsburg</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RFD#1, Box 206G, Federalsburg Md.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Preston</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Greenbury</b> MIDDLE <b>Griffith</b> LAST <b>Griffith</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b> MIDDLE <b>Nichols</b> LAST <b>Nichols</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-03-5428</b>		17. INFORMANT <b>Esther Griffith, Maple Ave., Md. 21655</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 87 to _____ 19 87, that (I) (we) lost saw the deceased alive on _____ 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William J. Banfield</i>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Banfield, M.D.</b>		22e. ADDRESS <b>505 Dutchmans Lane, Easton, Md. 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/23/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>	
23d. LOCATION CITY OR TOWN <b>Federalsburg, Caroline, MD</b>		23e. COUNTY <b>Caroline</b>		23f. STATE <b>MD</b>	
24. FUNERAL DIRECTOR <b>Framptom-Hawkins Fun. Hm.</b>		ADDRESS <b>PO Bx 43 Federalsburg, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 29 1987</b>	
				25b. REGISTRAR'S SIGNATURE <i>W. Gordon L. ...</i>	

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Franklin-Hawkins Farm, Inc. PO Box 43  
Federalburg, MD

Burial 12/22/87 Wilcrest Cem.

Federalburg, Caroline, MD

William J. Bantel, M.D. 205 Butchmans Lane, Easton, Md. 21601

No

212-03-2428 Esther Griffith, Maple Ave., Preston  
Md. 21657

Greenbury Griffith Ella x Maple Avenue  
Maryland Caroline Preston

Federalburg RFD 1, Box 206G, Federalburg Md.  
Homemaker Home Caroline

F White 12/04/03 84

WHITIE C.

BONNER

12/20/87

11:20P

076808 DEC 31 07

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

35423

1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE R. CAMPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-11-87</b>		2b. HOUR <b>7<sup>20</sup> PM</b>
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline County</b> MD.	
10. CITY OR TOWN OF DEATH <b>DENTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESLEYAN HEALTH CARE CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1002 Pine St. Camb., Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Josiah Roberts</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? ? ?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>213-12-5421</b>		17. INFORMANT (Daughter) ADDRESS <b>Mable C. Bailey 1002 Pine St. 21613</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gangrenous lower extremities</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dialysis Mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>April 87</b> <b>Years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>N/A</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>87</b> , to <b>December 11</b> 19 <b>87</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>Dec 11</b> 19 <b>87</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>Monica Agree</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/11/87</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Monica Agree MD</b>		22c. ADDRESS <b>Caroline Health Services Daffin Lane, Denton, MD 21629</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/17/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cordtown Dor., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Bowdley Funeral Home</b>		ADDRESS <b>21613 312 Hubbard St.</b>		25a. DECEASED BY REGISTRAR <b>DEC 22 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia T. ...</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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THE  
LIBRARY  
OF THE  
UNITED STATES  
DEPARTMENT OF  
AGRICULTURE  
WASHINGTON, D. C.



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 424

1. DECEASED NAME (TYPE OR PRINT) <b>RALPH WESLEY COHEE</b>				2a. DATE KNOWN OF DEATH ESTIMATED <b>Nov 15 1987</b>				2b. HOUR <b>2:00 A M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 5 1927</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>Nov 15 1987</b>		2d. HOUR <b>5:00 A M</b>	
7a. BIRTHPLACE (STATE OR COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CAROLINE</b> MD.			
10. CITY OR TOWN OF DEATH <b>Federsburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt 1, Box 70, Federsburg, MD 21632</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>CAROLINE</b>		13c. CITY OR TOWN <b>Federsburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GILBERT W. COHEE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY OLEVIA LANKFORD</b>		16a. SOCIAL SECURITY NO. <b>220-28-4683</b>		17. INFORMANT NAME ADDRESS <b>Louise N. Cohee (wife) same as 11 2601e</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT NAME ADDRESS <b>Louise N. Cohee (wife) same as 11 2601e</b>					
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Previous Myocardial Infarction</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Christian E. Jensen</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>11/18/87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Christian E. Jensen MD</b>		ADDRESS <b>P.O. Box 690, Denton MD 21629</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-17-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Federsburg, CAROLINE MD</b>			
24. FUNERAL DIRECTOR <b>Williamson Funeral Home</b>		ADDRESS <b>Federsburg MD 21632</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Jensen-Budner</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

RALPH WESLEY COFFE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 3 5 4 2 5  
REG. NO.FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lester Collins			2a. DATE OF DEATH MONTH DAY YEAR 11 24 87		2b. HOUR 4 32 P M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR OCT 28 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline County MD	
10. CITY OR TOWN OF DEATH Denton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Town Engineer	12b. KIND OF BUSINESS OR INDUSTRY Maint.	
13a. STATE Maryland		13b. COUNTY Catherine	13c. CITY OR TOWN Federalburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Academy Ave. Federalburg, Md. 21652
14. FATHER'S NAME FIRST MIDDLE LAST HARRY Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roxie Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A	
16b. SOCIAL SECURITY NO. 216-07-6868		17. INFORMANT ADDRESS Hazel Collins Academy Ave. Fed. Md. 21652			
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute Chronic					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ALZHEIMERS Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/10/87 to 11/24/87 that (I) (we) lost the deceased on 11/24/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. PHYSICIAN'S SIGNATURE Christian E. Jensen MD		22c. DATE SIGNED 11/24/87		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Christian E. Jensen MD		22f. ADDRESS P.O. Box 690, Denton MD 21629			
23a. BURIAL, CREMATION, REMOVAL (IF ANY) Burial		23b. DATE 11-27-87		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Federalburg Caroline Md.		24. FUNERAL DIRECTOR Williamson Funeral Home Federalburg, Md. 21632			
25a. DATE REC'D. BY REGISTRAR DEC 01 1987		25b. REGISTRAR'S SIGNATURE J. D. Anderson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

BP

White 80

11/11/70

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PENDING. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35426

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IDA MAE GARFIELD</b>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>12 14 1987</b>			2b. HOUR M <b>12:30</b>		
3. SEX <b>Female</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 14 1908</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>79 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 14 1987</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ind.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CAROLINE</b>		
10. CITY OR TOWN OF DEATH <b>FEDERALSBURG</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>CAROLINE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>310 PARK AVE MD</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Ricketts</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Taylor</b>		16. SOCIAL SECURITY NO. <b>213-16-8191</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				17. INFORMANT <b>Barbara Bolden</b>		ADDRESS <b>rt 1 box 13 Federalburg, md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASC DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Christian E. Jensen MD</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>12/14/87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>CHRISTIAN E. JENSEN MD</b>			ADDRESS <b>P.O. Box 690, Denton MD 21629</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-19-87</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Federal Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Federalburg Caroline md.</b>		
24. FUNERAL DIRECTOR NAME <b>Bennie J. Smith</b>		ADDRESS <b>Hurlock, md</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Valia Gordon-Randall</b>		

78101231 THE WINE GARFIELD

CHARGE

DID CHARGE technology & no fault A & B

Myocardial infarction

Myocardial infarction caused by blood clots

X X

Robert E. Jensen and Robert E. Jensen  
Robert E. Jensen and Robert E. Jensen

075186 DEC 10 1987

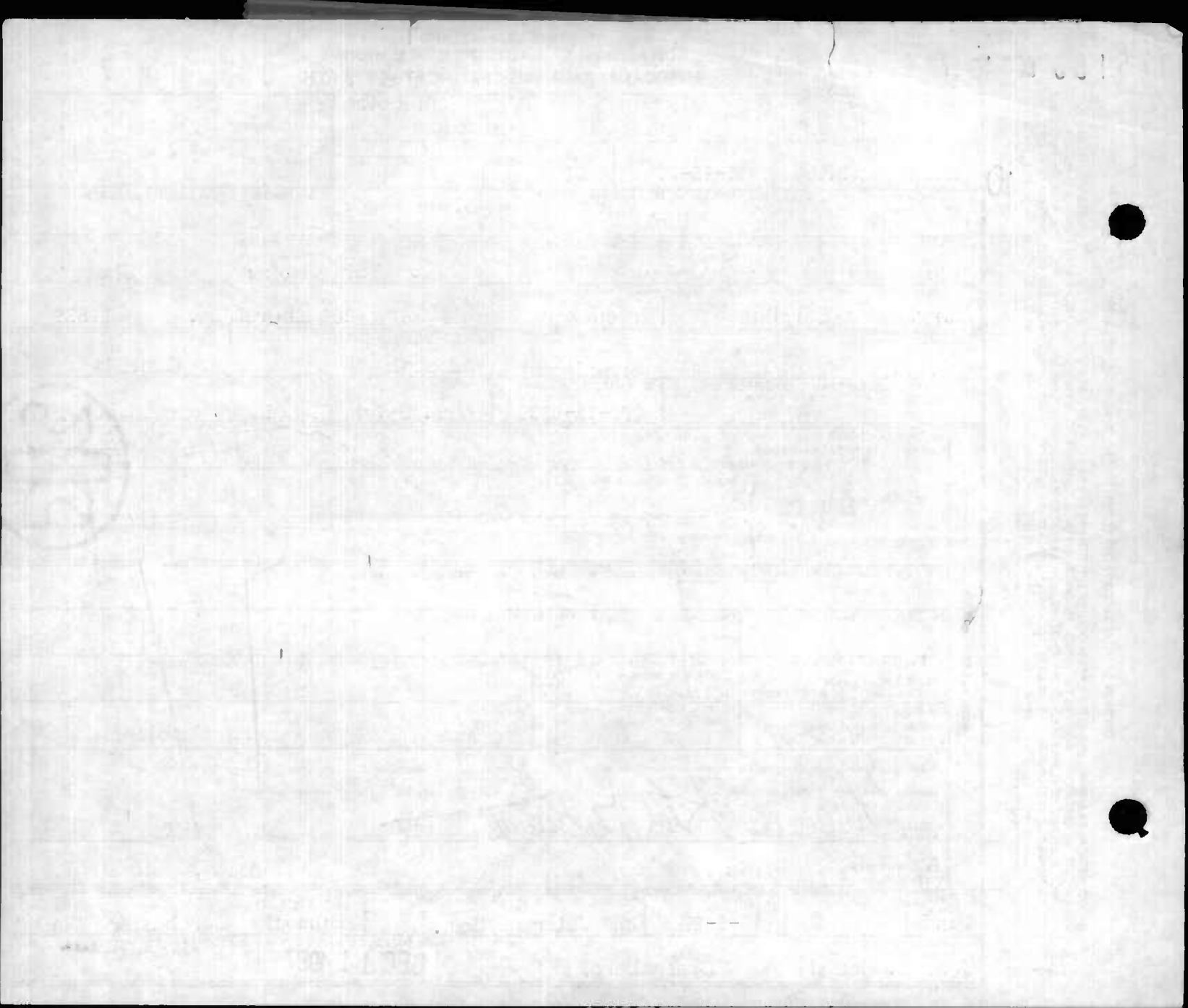
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3 5 4 2 7  
REC'D NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Anthony			MIDDLE F.			LAST Gianninoto			2a. DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/ 5/ 19 87			2b. HOUR M 2:12 P.M.														
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR 11-15-21			6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/ 5/ 19 87														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York						7b. CITIZEN OF WHAT COUNTRY? USA						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Caroline County, MD											
10. CITY OR TOWN OF DEATH Greensboro						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Church St.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe Maker						12b. KIND OF BUSINESS OR INDUSTRY Shoe											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Caroline						13c. CITY OR TOWN Greensboro						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 201 Church St. 21639					
14. FATHER'S NAME FIRST John MIDDLE MIDDLE LAST Gianninoto						15. MOTHER'S MAIDEN NAME FIRST Joseph MIDDLE MIDDLE LAST Cantellego						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes						16b. SOCIAL SECURITY NO. WW 11 095-12-0339						17. INFORMANT Mrs. Sylvia Gianninoto ADDRESS Greensboro, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Thermal Injuries & Smoke and Soot Inhalation IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30AM 12/5/ 19 87						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject in housefire																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home						21f. LOCATION STREET CITY OR TOWN COUNTY STATE 201 Church St., Greensboro, Caroline, Md.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>						TITLE (SPECIFY) Assistant						MEDICAL EXAMINER						DATE SIGNED 12/6/87											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 12-9-87						23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cem.						23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock Dorchester MD											
24. FUNERAL DIRECTOR NAME John E. Boulais						ADDRESS Greensboro, MD						25a. DATE REC'D. BY REGISTRAR DEC 11 1987						25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rodriguez</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM F-103. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 7 3 5 4 2 8

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Eleanor S. Ireland					12 03 87					420 A M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	WHITE		JULY 13 1900		87		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		U.S.A.				Caroline County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
DENTON		Caroline Nursing Home				Housewife				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE			
13a. STATE					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		513 ACADEMY AVENUE 21632			
13a. COUNTY					13c. CITY OR TOWN					
MD					FEDERALSBURG					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT				
JOSHUA		Flora Adams Sullivan		218-34-3221		Betty King				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						
NO		218-34-3221		Betty King						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) MASSIVE CEREBROVASCULAR accident ACUTE										
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS-generalized chronic										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ALZHEIMER'S DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/28 1987 to 12/13 1987, that (I/we) last saw the deceased alive on 11/28 1987, and that (in my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Christian E. Jensen MD		MD						12/3/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
CHRISTIAN E. JENSEN MD		P.O. Box 1690, Denton MD 21629								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE		
Burial		12/06/87		Hillcrest Cem.		Federalsburg, Caroline		MD		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS				DEC 08 1987		Julia Benson-Rudace				
Thampha Hanbuis 216 W. Main St. Fed., Md.										

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

100-10000

WHITE 87

MARTIN

DENTON

AND CAROLINE

ISLAND

AND CAROLINE

AND CAROLINE

AND CAROLINE

AND CAROLINE

AND CAROLINE

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AND CAROLINE

AND CAROLINE

AND CAROLINE

AND CAROLINE

Burial 12/06/87 Hillcrest Cem. Federalburg, Caroline MD

076794 DEC 3 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 5429

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret Bidwell Knotts</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 12 87</b>			2b. HOUR <b>3:20p M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 26 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b> MD		
10. CITY OR TOWN OF DEATH <b>Denton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Caroline Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>CAROLINE</b>		13c. CITY OR TOWN <b>DENTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALFRED SMITH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANE MARIA BRATT</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213440290</b>		17. INFORMANT ADDRESS <b>MARY ANN WALSH DENTON, MARYLAND</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>yes</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 week</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Bronchopneumonia, bilateral</b>								
19a. DATE OF OPERATION <b>2/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>March 22, 1985</b> to <b>Dec 12, 1987</b> , that (I) (we) last saw the deceased alive on <b>Dec 01, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Philip P. Felipe MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/13/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Philip P. Felipe MD</b>				22e. ADDRESS <b>DENTON, MD 21629</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12/13/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DELMARVA</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LEWES SUSSEX DEL.</b>		
24. FUNERAL DIRECTOR NAME <b>MOORE FUNERAL HOME DENTON</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John R. Anderson</b>		

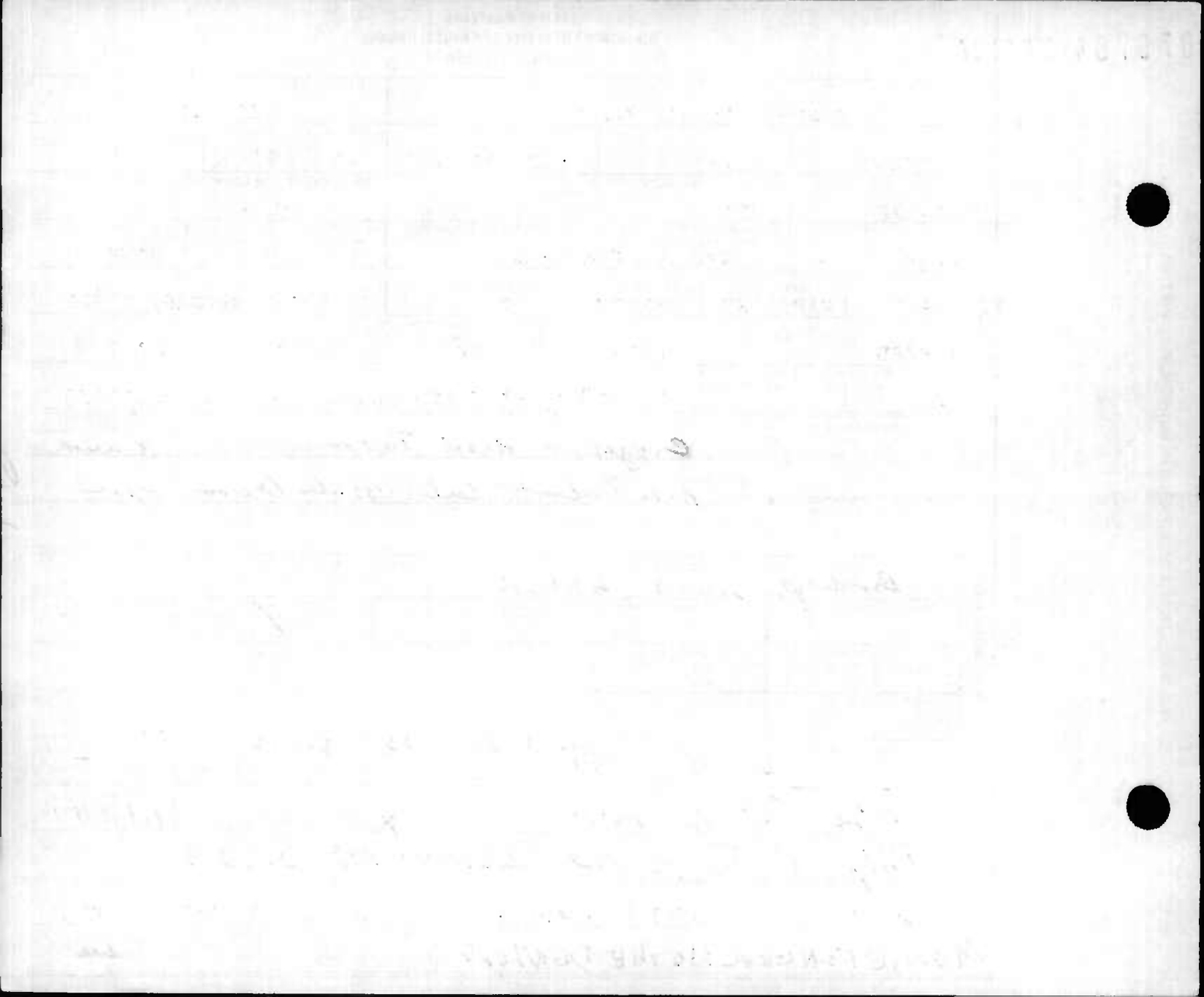
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



075555 DEC 21

FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

35430

1. DECEASED NAME (TYPE OR PRINT) F. NORWOOD MELVIN			2a. DATE OF DEATH MONTH DAY YEAR 11-28-87 5P M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Feb 8 1904	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7b. HOUR 5P
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD		
10. CITY OR TOWN OF DEATH FEDERALSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT #2, Box 184, Federalburg		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING
13a. STATE MARYLAND	13b. COUNTY CAROLINE	13c. CITY OR TOWN Federalburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FRED N. MELVIN		15. MOTHER'S MAIDEN NAME IDA WRIGHT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-36-1369		17. INFORMANT Mrs Ruth Melvin, same as item 13	

18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) INANITION, STASIS DUE TO, OR AS A CONSEQUENCE OF (c) CACHEXIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS chronic
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ALZHEIMERS DISEASE			
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did) (did not) view the body after death.		22b. DATE SIGNED 12.2.87
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22c. SIGNATURE Christian E. Jensen MD	22d. ADDRESS P.O. Box 690, Denton MD 21629
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23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 12-1-87	23c. NAME OF CEMETERY OR CREMATORY BLOOMERY CEMETERY	23d. LOCATION Federalburg Caroline MD
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24. FUNERAL DIRECTOR Williamson Funeral Home Fed. Md.	25. DATE RECEIVED BY REGISTRAR DEC 09 1987	26. REGISTRAR'S SIGNATURE Julia Anderson-Rudner
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 4 and 5 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

11-28-81

F. NORWOOD ALERIN

WHITE FLD 8 1901 83

ALERIN USA CAROLINE

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ALERIN CAROLINE FLD 8 1901 83  
ALERIN CAROLINE FLD 8 1901 83

NO 211-32-1301 this is not ALERIN, same as item 13

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ALERIN CAROLINE FLD 8 1901 83  
ALERIN CAROLINE FLD 8 1901 83



075792 DEC 22 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 5 4 3 1

1. DECEASED NAME (TYPE OR PRINT) <b>Stephen Roberts</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-13-87</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 - 8 - 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b> MD	
10. CITY OR TOWN OF DEATH <b>Henderson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hollingsworth Circle</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Henderson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Hollingsworth Circle 21640</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Roberts</b>		15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>Elizabeth Nanay</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213-16-8908</b>	17. INFORMANT ADDRESS <b>Mrs. Nona Roberts Henderson, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, small cell, left lung</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>09/08</b> 19 <b>87</b> to <b>12/13</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11/29/87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Phil P. Feupend</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/14/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Phil P. Feupend</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-16-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro CA MD</b>
24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>			ADDRESS <b>Greensboro, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1987</b>
					25b. REGISTRAR'S SIGNATURE <b>John E. Boulais</b>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COTTON FIBERS

CHERRY IN BOX

075503 DEC 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED IN THE DEATH RECORD, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 6 film G634 12-1-87 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 35432			
1- STATE per funeral home REGISTRAR sb										2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11-15 1987		2b HOUR 10 <sup>15</sup> AM	
DECEASED NAME (LAST FIRST MIDDLE) William L. Towers										2c DATE PRONOUNCED DEAD 11 15 1987		2d HOUR 10 <sup>15</sup> AM	
3. SEX m		4. RACE White		5. DATE OF BIRTH 9-25-32		6. AGE (IN YEARS) 55 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH FALLEN CAROLINE MD			
10 CITY OR TOWN OF DEATH Federalsburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21632 209 East Central Ave., Fed., Md. Dis. Mach.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trucking		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE M.D. 13b COUNTY CAROLINE 13c CITY OR TOWN Federalsburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 209 E. Central Ave. 21632							
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Towers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Caulk									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Korea				16b SOCIAL SECURITY NO. 220-28-4338				17 INFORMANT ADDRESS, Md. 21632 Willie Towers 209 E. Central Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute chronic			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Previous Myocardial Infarction.													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Christian Jensen				M.D. Deputy				DATE SIGNED 11/15/87					
EXAMINER'S NAME (TYPE OR PRINT) Christian E. JENSEN				ADDRESS MD P.O. Box 690, Denton MD 21629									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-18-87		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg Caroline Md.			
24 FUNERAL DIRECTOR Williamson F. Home ADDRESS Fed., Md. 21632						25. DATE REC'D BY REGISTRAR NOV 19 1987		26 REGISTRAR'S SIGNATURE					

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

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073971 DEC-3-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

3 5 4 3 3

1. DECEASED NAME (TYPE OR PRINT) James Burton Willey			2a. DATE OF DEATH MONTH DAY YEAR November 18, 1987			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Denton, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.				
10. CITY OR TOWN OF DEATH Preston, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 148				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Foreman		12b. KIND OF BUSINESS OR INDUSTRY Preston Truck		
13a. STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John Walter Willey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Towers			16. STREET ADDRESS Rt. 2, Box 148			21655	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII			17. INFORMANT Verna Willey, Rt. 2, Box 148, Preston			Md.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER (ADENOC) (b) (c) DUE TO, OR AS A CONSEQUENCE OF (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MO		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/17/87, 19 to 11/18, 1987, that (I) (we) last saw the deceased alive on 11/12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE Stephen P. Carney, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-20-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, MD					22e. ADDRESS Dutchman's Lane, Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 21, 1987		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dor., Maryland			
24. FUNERAL DIRECTOR NAME Framptom-Hawkins F.H. 216					ADDRESS N. Main St.		25a. DATE REC'D. BY REGISTRAR NOV 30 1987		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

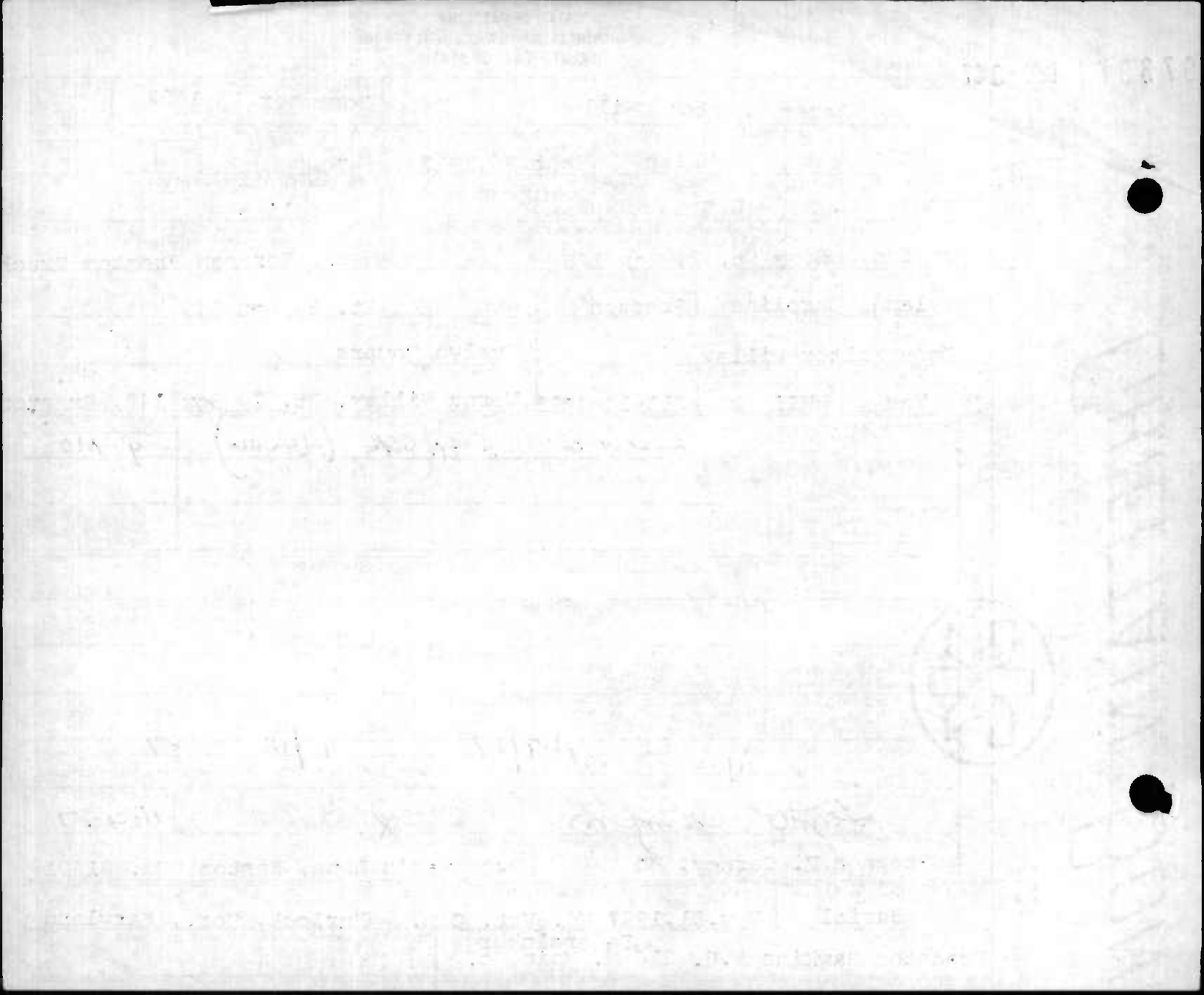
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

DHMH - 16 60M 7/73  
(VRA 15 (4))





074068 DEC-30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE "CPM-PAY" AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR 15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35434

FOR STATE REGISTRAR <b>Erna M. Woodard</b>										REG. NO.	
1. DECEASED NAME FIRST <b>ERNA</b> MIDDLE <b>WOODARD</b> LAST										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <b>28</b> YEAR <b>1987</b> HOUR <b>12</b> PM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>20</b> YEAR <b>1914</b>		6. AGE (IN YEARS) YEARS <b>73</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH <b>Nov</b> DAY <b>29</b> YEAR <b>1987</b> HOUR <b>4</b> PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CAROLINE</b> MD					
10. CITY OR TOWN OF DEATH <b>GREENSBORO</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Community Care Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>CAROLINE</b> CITY OR TOWN <b>Greensboro</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>HILL RD, Greensboro 21639</b> MD			
14. FATHER'S NAME FIRST <b>Emil</b> MIDDLE LAST <b>Kuhnert</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE LAST <b>Lehrfeld</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578-38-9297</b>		17. INFORMANT ADDRESS <b>Rockville, MD 20853</b> <b>Joseph M. Heller (son) 4944-Walkingfern Dr.,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>(b) DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c) ARTERIOSCLEROSIS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>chronic</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Insulin Dependent Diabetes, PSYCHOSIS</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Christian E. Jensen</b>				M.D. <b>DEPUTY</b> MEDICAL EXAMINER				DATE SIGNED <b>11/29/87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>CHRISTIAN E. JENSEN</b>				ADDRESS <b>PO. Box 690, Denton MD 21629</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>12-1-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN <b>Washington</b> COUNTY <b>District of Columbia</b> STATE			
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b>				ADDRESS <b>300-4th St., NE, Wash., DC 20002</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 03 1987</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Barber-Bandrich</b>			

DEC 03 1981

Christian E. Jensen and  
Deputy  
isolated

X X

chronic  
dental

Intermittent Diabetes, 1980-1982  
Arteriosclerosis  
Chronic Kidney Disease

x Hill Rd Greenwood  
x Hill Rd Greenwood

Female White 3 to 1914 13

Frank Woodard

CAROLINE  
Nov 24 81 48  
Nov 28 81 17